

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09031

9020

CERTIFICATE OF DEATH

Reg. Dist. No. 253

1. PLACE OF DEATH- COUNTY <u>Queen Annes</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Stevensville</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 yrs</u>		STREET ADDRESS (If rural, give location) <u>15 yrs</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Henry</u> (Middle) <u>Anderson</u> (Last) <u>Baker</u>		4. DATE OF DEATH (Month) <u>14</u> (Day) <u>1955</u> (Year) <u>9</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3-7-78</u>
9. AGE last birthday <u>77 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Capt. Fishing boat</u>	
11. BIRTHPLACE (State or foreign country) <u>Kent Island Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Isaac Baker</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, oo, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs H.A. Baker Stevensville Md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>443X</u> Immediate cause (a) <u>Myocarditis</u>		<u>2 yrs</u>
Antecedent cause(s) (b) <u>Hypertension arterio-sclerosis</u>		<u>4 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1952 to July 11, 1955, that I last saw the deceased alive on July 11, 1955, and that death occurred at 12.30 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Dr. Chas E. Snyder ADDRESS Stevensville Md DATE SIGNED 7 14 55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Sept. 17, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Stevensville Cemetery</u>	LOCATION (City, town, or county) (State) <u>Stevensville Maryland</u>
DATE REC'D BY LOCAL REG. <u>Sept. 17, 1955</u>	REGISTRAR'S SIGNATURE <u>Elizabeth Koster</u>	24. FUNERAL DIRECTOR <u>Baron Bros</u>	ADDRESS <u>Centreville Md</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 20 1955

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH

09032

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 254

9021

1. PLACE OF DEATH- COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>D.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Sallie</u>	(Middle) <u>Eliza</u>	(Last) <u>Beecher</u>
4. DATE OF DEATH	(Month) <u>Sept.</u>	(Day) <u>25</u>	(Year) <u>1955</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2/24/1874</u>
9. AGE last birthday <u>81</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clement Nutter</u>		14. MOTHER'S MAIDEN NAME <u>Mary Conway</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Margaret Smith - Queenstown</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
443X Immediate cause (a) <u>Hypertensive-Arteriosclerotic Cardio-Vascular Disease</u>		Yrs.	
Antecedent cause(s) (b) _____			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 9</u> , 19 <u>51</u> , to <u>Sept.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept. 11</u> , 19 <u>55</u> , and that death occurred at <u>5 A.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Wm. J. H. M.D.</u>		ADDRESS <u>Queenstown, Md.</u> DATE SIGNED <u>9/25/55</u>	
23. BURIAL, CREMATION REMOVAL, (Specify) <u>Burial</u>		DATE <u>Sept 27-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>		LOCATION (City, town, or county) (State) <u>Chesapeake Bay, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Sept. 27-55</u>		REGISTRAR'S SIGNATURE <u>Alan M. Uddridge</u>	
24. FUNERAL DIRECTOR <u>Barton Bros. Centerville, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 4 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9-22 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 213
 Reg. Dist. 09033

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Queen Anne's</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Stevensville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) X TOWN <u>Stevensville Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) <u>Baby Bay</u> (Middle) <u>Clark</u> (Last)		(Month) <u>Sept</u> (Day) <u>14</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>Sept 14-55</u>
9. AGE last birthday: <u>Yrs.</u>		10. BIRTHPLACE (State or foreign country): <u>Stevensville Md</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u>		11. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10b. KIND OF BUSINESS OR INDUSTRY:			
13. FATHER'S NAME: <u>Charles Clark Jr.</u>		14. MOTHER'S MAIDEN NAME: <u>Ada Elburn (Clark)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Charles Clark Jr. Stevensville Md</u>	
16. SOCIAL SECURITY No.: <u>none</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Premature birth 5 1/2 months pregnant.</u>			
DUE TO (b) <u>baby lived 5 minutes.</u>			
Antecedent cause(s) (c)			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21c. (City or town) (County) (State)		21d. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>W. Henry Fisher M.D. Centerville Md.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>9/15-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Sept 15, 55</u>	
NAME OF CEMETERY OR CREMATORY: <u>Stevensville</u>		LOCATION (City, town, or county) (State) <u>Stevensville Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Sept 15, 1955</u>		24. FUNERAL DIRECTOR <u>Barton B. P. Centerville Md.</u>	
REGISTRAR'S SIGNATURE <u>Glynneth Hoyle</u>		ADDRESS	

RECEIVED

SEP 20 1955

BUREAU V. 2

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9123 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09034			
Item 9, Film G186 9-19-55 et CERTIFICATE OF DEATH Reg. Dist. No. 252			
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Queen Anne</u> MARYLAND		STATE <u>MD</u> COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>	
OR TOWN <u>Centreville</u>		OR TOWN <u>Centreville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Brown St.</u>		STREET ADDRESS (If rural give location) <u>Brown St.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Charles Westly Conyers</u>		<u>9 7 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>11/24/78</u>
9. AGE last birthday <u>76</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Charles Conyers</u>		14. MOTHER'S MAIDEN NAME: <u>Rachel Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mrs. Jas. Fragie, Centreville, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
421.4 IMMEDIATE CAUSE (A) <u>Chronic valvular disease of heart</u>			
ANTECEDENT CAUSE (B) <u>Arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1-1</u> , 19 <u>55</u> to <u>9/7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9-6</u> , 19 <u>55</u> , and that death occurred at <u>5:4</u> M, from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>9-10-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9/12/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cem.</u>		LOCATION (City, town, or county) (State) <u>Centreville, MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9/10/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>James B. Dashiell, Centreville, Md.</u>		ADDRESS <u>[Address]</u>	

BUREAU V. 2

SEP 14 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

09035

2411 N. Charles Street, Baltimore

9024

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH- COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Centerville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Centerville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Margaret</u> (Middle) <u>DEAKER</u> (Last) <u>McKenny</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 10</u> 19 <u>55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept 23 - 1874</u>
9. AGE last birthday <u>82</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Montebello, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Montebello, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Jacobus Decker</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Bodine Keene Harvey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>John McKenny Centerville, Md</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.1 Immediate cause (a) <u>Myocardial Insufficiency</u>		3 yrs.	
Antecedent cause(s) (b) <u>Arteriosclerotic cardiovascular disease</u>		10-20 yrs.	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>53</u> , to <u>Sept 10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Sept. 9</u> , 19 <u>55</u> , and that death occurred at <u>1:20 P</u> .m., from the causes and on the date stated above.			
SIGNATURE <u>G.W. Martin, Jr. M.D.</u>		ADDRESS <u>Queenstown, Md.</u> DATE SIGNED <u>Sept. 10, 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>Sept 12-55</u>	NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>	LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>
DATE REC'D BY LOCAL REG. <u>Sept 10-55</u>	REGISTRAR'S SIGNATURE <u>Oliver Armstrong</u>	24. FUNERAL DIRECTOR <u>Barton Bros., Centerville, Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

SEP 14 1955

RECEIVED

9-25

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09036

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Queen Anne</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Queen Anne</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Queen Anne</u>	LENGTH OF STAY (in this place) <u>20 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Queen Anne</u>	TOWN <u>Queen Anne</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>1</u>	
3. NAME OF DECEASED: (First) <u>Christopher</u> (Middle) <u>Nichols</u> (Last) <u>Nichols</u>		4. DATE OF DEATH: (Month) <u>Sept</u> (Day) <u>26</u> (Year) <u>1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Feb. 28, 1872</u>
9. AGE last birthday: <u>83</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Home owner</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Farming</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>unknown</u>		14. MOTHER'S MAIDEN NAME: <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>unknown</u>	
17. INFORMANT'S ADDRESS: <u>Mrs. Christopher Nichols, Queen Anne, Md.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
421.4 Immediate cause (a) <u>Chronic Valvular disease of the heart</u>			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Arterio-Sclerosis</u>			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <u>9-26</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-26</u> , 19 <u>55</u> , to <u>Sept 26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/26</u> , 19 <u>55</u> , and that death occurred at <u>1 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>H. J. McPherson M.D.</u>		DATE SIGNED <u>9/28/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Sept. 29, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		LOCATION (City, town, county) <u>Hillsboro, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Sept. 28-55</u>		REGISTRAR'S SIGNATURE <u>Ellice Armstrong</u>	
24. FUNERAL DIRECTOR <u>J. Virgil Brown</u>		ADDRESS <u>Say, Dutton, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 30 1955

BUREAU V. 2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9926

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09037

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 252

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Queen Anne</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>near Waynesville</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Stellaboro</u> 05x-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First)	(Middle)	(Last)	(Month) (Day) (Year)
<u>Victor Vaughan Pepper</u>		<u>Sept 27 1955</u>	
5. SEX:	6. COLOR OR RACE	7. SINGLE MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:
<u>male</u>	<u>white</u>		<u>Sept 19-1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Garage owner</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Auto</u>	9. AGE last birthday: <u>51</u> yrs.
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Geo. Pepper</u>		14. MOTHER'S MAIDEN NAME: <u>Emma Butler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Pepper (wife) Stellaboro md</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
<p>420.1 Immediate cause (a) <u>Coronary Occlusion</u> DUE TO</p> <p>Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)</p>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE		CHIEF MEDICAL EXAMINER	DATE SIGNED
<u>W. Henry Fisher - Centerville md</u>		DEPUTY MEDICAL EXAMINER	<u>9/27-55</u>
23. BURIAL, CREMATION, REMOVAL (Specify):		24. FUNERAL DIRECTOR	
DATE THEREOF		LOCATION (City, town, or county) (State)	
<u>Sept 30 1955</u>		<u>Denton Md</u>	
NAME OF CEMETERY OR CREMATORY		ADDRESS	
<u>Denton</u>		<u>J. V. Moore & Son</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE		<u>Denton</u>	
<u>Sept 28 1955</u>			

RECEIVED

SEP 30 1955

BUREAU V. A.

9027
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 352

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Queen Anne's</u>	MARYLAND	STATE <u>Wisconsin</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
X TOWN <u>Waukegan</u>		TOWN <u>Rhinelander</u>	<u>86 X-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
		<u>1003 Eagle St</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>DVANE</u>	(Middle) <u>S</u>	(Last) <u>PULVER</u>	(Month) <u>Sept</u> (Day) <u>3</u> (Year) <u>1956</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>Dec 9 - 1929</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <u>25</u> yrs.
11. BIRTHPLACE (State or foreign country): <u>Rhinelander Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Hayes E. Pulver</u>		14. MOTHER'S MAIDEN NAME: <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>?</u>	
<u>2 yrs</u>		17. INFORMANT & ADDRESS: <u>Medical Records -</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<u>916.0</u> Immediate cause (a) <u>Burned to death when house burned</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
<u>near Janesville - 2 A</u>	<u>17</u>	<u>Ind</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>W. Harvey Fisher M.D. - Centerville Ind.</u>		
CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>9/3-55</u>		
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>9-8-55</u>	NAME OF CEMETERY OR CREMATORY: <u>Forest Hill</u>
LOCATION (City, town, or county) (State): <u>Rhinelander - Wisconsin</u>	24. FUNERAL DIRECTOR ADDRESS: <u>Barton Bros. Centerville Ind.</u>	
DATE REC'D BY LOCAL REG. <u>9/4/55</u>	REGISTRAR'S SIGNATURE: <u>Elmer Armstrong</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 8 1955

BUREAU V. 2

9028

09039

Reg. Dist. 251

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 2525

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Queen Anne</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Queen Anne</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
X TOWN <u>near Crumpton</u>	<u>a few hours</u>	TOWN <u>Centerville</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
		1	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Blanche</u>	(Middle) <u>A.</u>	(Last) <u>Ruiggold</u>	(Month) <u>Sept</u> (Day) <u>24</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Cal</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Single</u>	8. DATE OF BIRTH: <u>Don't know</u>
9. AGE last birthday: <u>80</u> yrs.		10. IF UNDER 1 YEAR: Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY: <u>nurse</u>	
11. BIRTHPLACE (State or foreign country): <u>2 a Co md</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>? Ayers</u>		14. MOTHER'S MAIDEN NAME: <u>Don't know</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Julia Nelson - Centerville Md</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
331X Immediate cause		
(a) <u>She fell in her bed room 2 weeks ago +</u>		<u>memorial</u>
DUE TO <u>fractured right femur - 3 sent last to</u>		
(b) <u>Hospital Easton Md for treatment - a few days later she</u>		
DUE TO <u>developed a Cerebral Hemorrhage -</u>		
(c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>July 30 - 1955 8 a.m.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Fell in her bed room</u>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , or Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>W. Henry Fisher M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>9/24-55</u>		
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>Sept 26-55</u>	NAME OF CEMETERY OR CREMATORY <u>Christfield</u>
LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	24. FUNERAL DIRECTOR ADDRESS <u>Barton Bros. Centerville Maryland</u>	
DATE REC'D BY LOCAL REG. <u>9/26/55</u>	REGISTRAR'S SIGNATURE <u>Edgar L. Laney</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 30 1955

BUREAU V. S.

9-29

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Queen Anne</u>	MARYLAND	STATE <u>Louisiana</u>	COUNTY <u>Orleans</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chestertown</u>	LENGTH OF STAY (in this place) <u>16 Months</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>New Orleans</u>	<u>17X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Queen Anne Co.</u> <u>R. F. D.</u>		STREET ADDRESS (If rural give location) <u>1</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) <u>Annie</u>	(Middle) <u>Clark</u>	(Last) <u>Spencer</u>	<u>Sept. 22</u> 19 <u>55</u>
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH: <u>July 21, 1870</u>
9. AGE last birthday <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>retired</u>	11. BIRTHPLACE (State or foreign country): <u>Louisiana</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Wm. Lobell Clark</u>	
14. MOTHER'S MAIDEN NAME: <u>Elizabeth Devall</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS: <u>Mrs. Stephen R. Collins</u> <u>Chestertown Maryland</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Routine arrest</u>			<u>none</u>
ANTECEDENT CAUSE (S) (B) <u>Coronary sclerosis -</u>			<u>Don't know</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>"Little" stroke - 2 or 3</u>			<u>6 months</u>
19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>9/2</u> , 19 <u>55</u> to <u>9/22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9/12</u> , 19 <u>55</u> , and that death occurred at <u>6:00</u> P.M., from the causes and on the date stated above.			
SIGNATURE <u>Robert W. [unclear]</u>		DATE SIGNED <u>9/23/55</u>	
M. D. <u>Chestertown, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Sept. 26, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Metairie Ridge Cem.</u>	LOCATION (City, town, or county) (State) <u>New Orleans Louisiana</u>
DATE REC'D BY LOCAL REGISTRAR <u>9-24</u>	REGISTRAR'S SIGNATURE <u>Edgar R. Rane</u>	24. FUNERAL DIRECTOR ADDRESS <u>J. Willis Wells - Chestertown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OCT 5 1955

BUREAU V. 2

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 251

9:30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Queen Anne</u>		MARYLAND		STATE <u>Md.</u>		COUNT <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural Ingleside</u>				OR TOWN <u>Rural Ingleside</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) /			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>John Walter Walls</u>				OF DEATH: <u>Sept. 29 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Divorced</u>	<u>Mar. 20-1904</u>	<u>51</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Carpenter</u>		<u>Building</u>		<u>221-12-4151 Maryland</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Charles Walls</u>				<u>Elizabeth Barcus</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>No</u> (If Yes, give war or dates of service)		<u>221-12-4151</u>					
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
196X IMMEDIATE CAUSE (A) <u>Cancer of left lower jaw</u>							<u>18 mos.</u>
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-8</u> , 19 <u>55</u> , to <u>9-29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9-26</u> , 19 <u>55</u> , and that death occurred at <u>4:05</u> M, from the causes and on the date stated above.							
SIGNATURE <u>ac'ick</u>		M. D. <u>Chapman, Md.</u>		DATE SIGNED <u>10-1-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 2</u>		<u>Church Hill</u>		<u>Church Hill, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>10-1</u>		<u>Edgar L. Lane</u>		<u>Edgar L. Lane</u>		<u>Church Hill, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

HEALTH AND STATE DEPARTMENT OF CALIFORNIA

BUREAU V.

NOV 5 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9'31

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1809042

CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Queen Anne's</u> MARYLAND		CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Queenstown</u>		STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>	
X TOWN <u>Queenstown</u>		LENGTH OF STAY (in this place) <u>10 yrs</u>		STREET ADDRESS (If rural give location) <u>1</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>MARY FRANCES WOOLFORD</u>				OF DEATH: <u>Sept 18 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Sept 24 - 1875</u>	9. AGE last birthday: <u>79</u> yrs.	IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>retired</u>		11. BIRTHPLACE (State or foreign country): <u>Queen Anne's Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Vincent Briscoe</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>no</u>		16. SOCIAL SECURITY NO.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs. Lee Simey, Queenstown Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute cardiac failure</u>						<u>10 min</u>	
ANTECEDENT CAUSE (B) <u>Myocardial insufficiency</u>						<u>5 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerotic hypertensive cardio-vascular disease.</u>						<u>15 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1957</u> , to <u>Sept 18 1955</u> , that I last saw the deceased alive on <u>Sept. 12, 1955</u> , and that death occurred at <u>9 25 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>G. Wm. Martin, Jr.</u>		M. D. <u>Queenstown, Md.</u>		DATE SIGNED <u>9/20/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 21-55</u>		NAME OF CEMETERY OR CREMATORY <u>Hillsboro, Greensboro</u>		LOCATION (City, town, or county) (State) <u>Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Sept. 21-55</u>		REGISTRAR'S SIGNATURE <u>Allen M. Aldridge</u>		24. FUNERAL DIRECTOR <u>Barton Bep. Culverth Md.</u>		ADDRESS	

SEP 23 1955

RECEIVED